ISSUES IN COVERAGE FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE SERVICES:

Report of the Clinician Workgroup on the Integration of Complementary and Alternative Medicine

January 2000

Washington State
Office of the Insurance Commissioner
14th & Water Street
PO Box 40255
Olympia, WA 98504-0255

Phone: 360-753-7300
Fax: 360-586-3535
Internet: http://www.insurance.wa.gov

Deborah Senn
Washington State Insurance Commissioner

ACKNOWLEDGEMENTS

A special note of recognition is made to the following persons for their time and commitment to the development of the Clinician Workgroup on the Integration of CAM and the ongoing activities. The committee met for a three year period of regularly scheduled meetings which consumed a great deal of time to work on very difficult issues. Each participant should also be recognized for their ongoing individual presentations that took place throughout the three years. Without their input this report would not be possible. Thank you for your contributions.

Clinician Workgroup on the Integration of CAM
Workgroup Participants by Licensed Profession
1997-1999

Acupuncture (including licensed acupuncture participants)

Jim Blair, LAc, Acupuncture Association of Washington
Carl Dahlgren, Lac, Acupuncture Association of Washington
Pat Flood, LAc, Acupuncture Association of Washington
*Christopher Huson, LAc, Acupuncture Association of Washington
Susan Kaetz, External Clinics Manager, Northwest Institute of Acupuncture and Oriental Medicine
Bruce Sturgeon, LAc, MOM, Clinical Dean, Northwest Institute of Acupuncture and Oriental Medicine
Barbara Mitchell, JD, LAc, National Acupuncture and Oriental Medicine Alliance

Chiropractic (including doctor of chiropractic participants)

Dennis Dilday, DC, Washington State Chiropractic Association
Bruce Frickelton, Executive Director, Washington State Chiropractic Association
*John Huber, DC, Washington State Chiropractic Association
Austin McMillin, DC, Washington State Chiropractic Association
Robert Mootz, DC, Associate Medical Director, Washington State Labor and Industries
Jan Simon, Past Executive Director, Washington State Chiropractic Association

Dietetics (including registered dietitian participants)

Adrienne Dorf, RD
Peggy Gerlock, RD, Washington State Dietetic Association
Mary Kopriva, RD
*Suzzanne Myer, RD, Bastyr University
Debbie Nagy-Nero, RD, Washington State Dietetic Association
Kyle Unland, RD, Washington State Dietetic Association

Massage Therapy (including licensed massage therapist participants)

Lucy Baker, LMP, American Massage Therapy Association, Washington Chapter
Chris Casey, LMP, Ashmead College
Barbara Grigsby, LMP, American Massage Therapy Association, Washington Chapter
Ginger Lewis, LMP, Renton Technical College, Massage Program

Wendy Lippmann, LMP, American Massage Therapy Association, Washington Chapter
Beth Oppliger, LMP, Brian Utting School of Massage
*Susan Rosen, LMP, American Massage Therapy Association, Washington Chapter
*Dawn Schmidt, LMP, Brenneke School of Massage
Dee Spath, LMP, American Massage Therapy Association, National Standards of Care Special Committee
Diana Thompson, LMP, American Massage Therapy Association, National Standards Committee
Carl Wilson, LMP, American Massage Therapy Association, Washington Chapter

Conventional Medicine (including medical doctor participants)

Jim Bender, MD, Virginia Mason Medical Center
John Castiglia, MD, Premera Blue Cross (previously representing Regence BlueShield)
Rocky Frederickson, MD, Providence Health Plan
Hanns Haesslein, MD, Providence Seattle Medical Center
Elaine Jong, MD, Hall Health Primary Care Center, UWAMC
Gary Kaplan, MD, Virginia Mason Medical Center
Richard Layton, MD, Retired, Medalia Health Care
Rayburn Lewis, MD, Providence Seattle Medical Center
Jeff Livovich, MD, Aetna US HealthCare
Geoffrey MacPherson, MD, Pacificare of Washington
Laura Patton, MD, Group Health Cooperative of Puget Sound
Jeff Robertson, MD, Regence BlueShield
Ron Schneeweiss, MD, University Physicians
Mark Solleck, MD, Regence BlueShield
Art Spenkle, MD, Premera Blue Cross (Previously representing Qual Med Washington Health Plans)
Eugene Sun, MD, Pacificare of Washington
Allen Sussman, MD, Valley Medical Center
Pat Temple, MD, University of Washington Physicians
Peter West, MD, Premera Blue Cross
Mellicent Whinston, MD, Community Health Plan
Ze'ev Young, MD, UnitedHealthcare (Previously representing Regence BlueShield)

Midwifery (including licensed midwife participants)

*Heike Doyle, LM, Midwives Association of Washington
Sarah Huntington, LM, Midwives Association of Washington
*Jo Anne Myers-Ciecko, MPH, Executive Director, Seattle Midwifery School

Naturopathic Medicine (including naturopathic physician participants)

*Craig Baldwin, ND, Washington Association of Naturopathic Physicians
*Jennifer Booker, ND, American Complementary Care Network
*Robert Martinez, ND, DC, American Complementary Care Networks
*Robert May, ND, Alternare Health Services
*Bruce Milliman, ND, Washington Association of Naturopathic Physicians
*Pamela Snider, ND, Bastyr University
*Eileen Stretch, ND, American WholeHealth Network

Nurses (including nurse participants)

Marian Broida, RN, Regence BlueShield
Mary Dean, RN, Multicare
Margo Forstrom, RN, Multicare
Maureen Pence, RN, Community Health Plan
Debbie Smith-Fedon, RN, BSN, UnitedHealthcare

University of Washington Volunteer

Vizma Schulmeisters, MSW, Research support staff for CWIC

Facilitators

Lawrence Jacobson, Managed Healthcare Resources Northwest, LLC, 1997-1999
John Weeks, Publisher, Editor, *THE INTEGRATOR for the Business of Alternative Medicine*, 1997-1998

Workgroup Coordinator and Technical Support Staff

Lori L. Bielinski, LMP, Health Policy Analyst, Office of the Insurance Commissioner
Ann Eddy, Assistant to the Deputy Commissioner, additional support staff for committee

*Note: Presenters for the draft seed algorithm presentations in September and October of 1999 are indicated by an asterisk next to their name in the above list.

Additional Acknowledgements

Group Health Cooperative of Puget Sound and Regence BlueShield are acknowledged for their ongoing accommodations of meeting space.

EDITORS

Lori L. Bielinski, LMP, Health Policy Analyst
Robert D. Mootz, DC, Associate Medical Director, Department of Labor and Industries

Special committee on report writing
Lori Bielinski, Robert May, Bruce Milliman, Robert Mootz, Laura Patton, Barbara Stenson, Allen Sussman, Peter West, and Lawrence Jacobson

Special committee on editing
Lori Bielinski, Ann Eddy, Lawrence Jacobson, Bruce Milliman, Robert Mootz, Laura Patton, Barbara Stenson, Allen Sussman, and John Weeks

OUTSIDE PRESENTERS

Additional acknowledgements are made to those health care providers and organizations that presented to the Clinicians Workgroup in addition to the regular participants. Without the presentations of the following people the discussions of integration and the detail of running a truly integrated clinic may have been limited. For these presenters we extend our appreciation for their time to present and prepare to educate us about their experiences. Thank you very much

Clinician Workgroup on the Integration of CAM
Outside Presenter's by Organization

Alternare of Washington (now Alternare Health Services)
Darrell Stewart, Former President

Center for Comprehensive Care
Pam Driscoll, BSN

Community Health Centers of King County/Kent Community Clinic
Thomas Trompeter, Executive Director

Group Health Center for Health Studies
Dan Cherkin, PhD, Affiliate Professor of Family Medicine and Health Services, University of Washington

Group Health Cooperative
Simeon Rubenstein, MD
Matt Handley, MD

Harborview Medical Center, Complementary Medicine Clinic
Dedra Buchwald, MD
Heidi Sitton, RN

Premera Blue Cross
Richard Winner, Vice President

Pro-West
William McKee, MD

Puget Sound Birth Center
LeeAnne Shelley, LM

Puget Sound Physician's Association
David Burkebile, MD, Interim Medical Director

Quality Midwifery Associates
*Victoria Taylor, LM

Regence BlueShield
John Castiglia, MD

Seattle Cancer Treatment and Wellness Center
Patrick Donovan, ND
Kim Carlson, Administrator

Seattle Healing Arts
Zhi Ping Kouloch, LAc
Fernando Vega, MD, ND

Swedish Hospital, Dean Ornish Program
Suzanne Westcott, RN
Sarah Speck, MD, MPH

*Note: Presenters for the draft seed algorithm presentations in September and October of 1999 are indicated by an asterisk next to their name in the above list.

The following organizations participated in the funding of the outside facilitation:

Health Insurance Carriers
Aetna US Healthcare
Group Health Cooperative of Puget Sound
Pacificare of Washington
Premera Blue Cross
Qual Med Washington Health Plan
Regence BlueShield
UnitedHealthcare

Provider Professional Associations
Acupuncture Association of Washington
American Massage Therapy Association, Washington Chapter
Midwives Association of Washington State
Washington Association of Naturopathic Physicians
Washington State Chiropractic Association
Washington State Dietetic Association

Physician and Hospital Groups
Multicare Health System
Sisters of Providence Health System
Swedish Medical Center
University of Washington Medical Center
Valley Medical Center
Virginia Mason Medical Center

CAM Provider Networks
Alternare Health Services
American Complementary Care Network
American WholeHealth Network

CAM Educational Institutions
Ashmead College
Bastyr University
Brenneke School of Massage
Brian Utting School of Massage
Northwest Institute of Acupuncture and Oriental Medicine (NIAOM)
Seattle Midwifery School

Office of the Insurance Commissioner
financial participation, committee coordination, technical participation, and staff support

Table of Contents

Issues in Coverage for Complementary and Alternative Medicine Services:

Report of the Clinician Workgroup on the Integration of Complementary and Alternative Medicine

Executive Summary

This report documents the establishment and work of the Clinician Workgroup on the Integration of Complementary and Alternative Medicine (CWIC). This three-year process initiated by the Office of the Insurance Commissioner represents a constructive partnership between the public and private sector as well as health insurance carriers and providers. Participants included complementary and alternative medical health care providers, conventional medical providers employed in health insurance companies, primary care providers working in primary care organizations, educators of complementary and alternative medical students, and representatives of state regulatory agencies. One of CWIC's charges was to identify the many issues related to insurance coverage for services that may be considered "complementary and alternative" to "conventional" medical services. One of the most powerful outcomes from CWIC was the positive working relationships developed between the various participant communities. Some of the terms used in this report are specifically defined within the text, in footnotes, and/or appendices to clarify their usage. It is recognized that some terms may have other meanings that should not be extrapolated beyond the context intended here.

The Environment Preceding the Clinician Workgroup on the Integration of Complementary and Alternative Medicine - CWIC

In 1993, health care reform legislation was enacted by the Washington State Legislature that included provisions assuring consumers in Washington could buy health insurance even if they were sick or had changed jobs. Several provider groups pursued inclusion of all licensed providers in the state for insurance reimbursement of services within their respective practice scopes. To preserve the insurers' ability to select competent and efficient providers, the final legislation settled on the term every category, or type, of licensed provider being reimbursable, without mandating inclusion for every individual practitioner. Subsequent revisions to the law preserved these aspects of reform and the Office of the Insurance Commissioner (OIC) promulgated administrative rules to implement the legislative intent. Concurrent with and following court challenges, efforts were made by the OIC to pursue non-adversarial processes to identify issues, barriers, and solutions for implementing legislatively mandated changes.

The first attempts at initiating these processes included discussions about coverage options for complementary and alternative medicine (CAM), services as well as how carriers would credential providers for their networks. These meetings were initially legally focused and were shifted to a more clinical direction after the agreement to include outside facilitation was made.

Formation of Workgroup - CWIC

The Office of the Insurance Commissioner's health policy staff and outside facilitators met with provider groups to identify those categories that would be most affected by this law. A series of informal discussions with health care practitioners helped identify those considered CAM, licensed by the Department of Health, and caring for patients with health conditions covered by the Washington State Basic Health Plan. Simultaneously, facilitators conducted face-to-face and telephone interviews with potential participants to further refine issues of interest and concern.

A representative group of payer medical directors and CAM providers was established using criteria that insured balance and emphasized provider experience. External

independent facilitation was arranged and funded privately by the group participants themselves. In-kind OIC staff resources were provided, but the majority of direct costs for this effort were borne by the carriers and providers themselves.

Health Insurance Carriers
- Aetna US HealthCare
- Community Health Plan
- Group Health Coop of Puget Sound
- Pacificare of Washington
- Premera Blue Cross
- Qual Med Washington Health Plans
- Regence BlueShield
- UnitedHealthcare

CAM Provider Associations
- Acupuncture Association of Washington
- American Massage Therapy Association, Washington Chapter
- Midwives Association of Washington State
- Washington Association of Naturopathic Physicians
- Washington State Chiropractic Association
- Washington State Dietetic Association

Physician Organizations
- Hall Health Primary Care Center
- Multicare
- Providence Health System
- Providence Seattle Medical Center
- University of Washington Physicians
- Valley Medical Center
- Virginia Mason Health Plans

Network Providers
- Alternare Health Services
- American Complementary Care Network
- American WholeHealth Network

Educational Institutions
- Ashmead College
- Bastyr University
- Brenneke School of Massage
- Brian Utting School of Massage
- Northwest Institute of Acupuncture and Oriental Medicine
- Renton Technical College
- Seattle Midwifery School

1998 CWIC Activities

An aggressive agenda was proposed to address coverage decisions, technology assessment, medical necessity, data collection and the gathering of literature on costs and practices, exploration of holistic[1] health care versus condition care, and integration of CAM services. A variety of approaches were used, including didactic presentations by outside experts or group participants, workshops and training, literature and survey research, group discussion, and/or facilitated decision-making. For obvious logistical and efficiency reasons, experts within Washington State were used.

1998 CWIC meeting topics included: Inventory of existing standards for CAM practices; status of coverage and use of CAM services by carriers and physician groups; carrier procedures for technology assessment, medical necessity determinations and coverage decisions; survey of CAM patients' views of perceived benefits; clinical guideline training; CAM as add-on versus replacement to conventional care in high cost conditions; CAM integration into conventional delivery settings.

1999 CWIC Activities

The next full year of CWIC was directed at: Exploration of existing successful integrated CAM and conventional medical (CM) practices and development of draft clinical care pathways, algorithms, and protocols by participant CAM organizations; training of participant representatives in written clinical care pathway development; development of draft examples of clinical care pathways for conditions that the respective CAM providers might commonly address; identification of possible next steps for the group or future spin-offs; and research opportunities. Dedicated training was aimed at using evidence review as well as expert and community-based consensus development to draft written protocols in a way that non-CAM providers could apply within their respective professional communities.

1999 CWIC meetings topics included: Multidisciplinary clinic presentations; discussion on insurable practices; clinical care pathway and algorithm training; CAM practices survey project presentation; discussion on high cost conditions; research planning with University of Washington and Bastyr University researchers interested in CAM; presentations from Bastyr University, University of Washington and CWIC participants; presentation of draft algorithms by

[1] Of or relating to wholism, emphasizing the importance of the whole and the interdependence of its parts. For the purposes of this report, the use of the word "holistic" should be considered to include health promotion, disease treatment and prevention, and wellness. The term does not fully reflect the range of differences in paradigms between CAM disciplines.

participants; and summarizing of CWIC experience and review of material and information for the final report.

Variations in Coverage Strategies for CAM

There are currently several different coverage models for CAM services in use in Washington State. No preferred or "right" ways of including these benefits are being recommended by CWIC or OIC. Each approach has advantages and limitations for various constituencies.

- *Dollar Cap*: Applies maximum dollar expenditure per coverage year for a set range of CAM services.
- *Condition Based*: This CAM coverage model bases benefits on allowances related to specific clinical diagnoses or conditions. The covered benefit may require specific clinical regimens to have been followed prior to referral for CAM services.
- *Gatekeeper Method*: Characteristic of managed care coverage. Use of CAM requires direct referral from PCP gatekeeper, and benefits follow a medical necessity model. Some carriers include naturopathic physicians as PCPs.
- *Open Access Model*: Built on integration and coordination without a gatekeeper. This design allows a member to access network providers of all categories without the requirement of a PCP referral.
- *Self-referral and Preventive Care*: This model is usually structured as a rider to a core benefits package and usually follows a medical necessity model for coverage decisions. This could include patient access to a set number, or amount, of services without PCP referral, but require referral for additional coverage.
- *Discount Networks*: Some carriers have negotiated with CAM providers to provide discounts to their members, but do not provide reimbursement for the members' expenses for the services. This approach attempts to enhance access to CAM providers but does not reimburse for any of the services.

Lessons Learned

- Better understanding of each other's language and philosophies is needed.
- A forum of insurers and providers is a valuable environment for discussing coverage, payment and cost concerns.
- Creation of resources is needed for use in other like forums.
- Building trust and relationships breaks down barriers.
- The CWIC process increased awareness of the multifaceted nature of the current health care delivery system.
- Payers began to see the value in CAM delivery experience; providers gained understanding of managed care systems and payer issues.
- Practice guidelines have become integral in conventional medical delivery settings and assist payers in gauging medical necessity as well as appropriateness of care.
- CAM providers could benefit from broader application of quality improvement protocols to reduce variation and document improvement in patient progress and overall outcomes.
- Many of the changes in health care have resulted from marketplace factors that are frequently beyond the direct influence of providers, payers and regulators.

Next Steps

- Research should be a top priority. Specifically, cost data, claims experience, utilization appropriateness and other health services research issues will need to be better understood to assist in making coverage decisions.
- Care management considerations need to be explicitly addressed. Clinical guidelines and condition specific care pathways will assist CAM providers in conveying clinical rationale and the need for coverage determinations. Attention to these issues can also help CAM providers better understand their approaches and address practice variation.
- Education was an important by-product of the CWIC experience, and a forum to allow that to continue should be considered. CAM providers who can communicate well and can be made available should be identified.
- A collaborative forum for communication between payers, CM providers, CAM providers, and regulators should be established, perhaps at the national level.
- Integration of CAM and CM services was an ongoing theme throughout the CWIC process. Additionally, members felt that options and approaches for integration should be explored and inventoried.
- Delineation of care thresholds, financing mechanisms, and the quantification of cost-benefits for CAM and other preventative services will need to be prioritized.
- In general, sources of funding and resource support need to be identified for all of these activities.

Key Issues Regarding Integration

- Relationship Development: Mutual respect and recognition of perspectives is essential.

- Speaking Different Languages: Patience and openness is required regarding differences in training and

experience, hence the syntax used for communicating each other's views and needs.

- Learning Each Other's Paradigms: Attitudes toward healing, intervention, care coordination may vary between CAM approaches and compared to CM approaches. Appreciation for how this impacts approaches to care is essential for coordination and integration.
- Algorithms and Guidelines: Recognition of these tools for both improving quality and outcome of care, along with communicating CAM care decisions and thresholds is important. Documentation of recognized limitations and strategies for preventing inappropriate use are essential.
- Research Support: The absence of research in support of a particular intervention's effectiveness should not by default be treated as though there was scientific evidence demonstrating ineffectiveness.
- Members May Have Different Needs: Each constituent, payer, CAM provider, CM provider and regulator has different perspectives, needs and accountable bodies that must be recognized. A forum for constructive engagement and problem solving is essential.

Recommendations of CWIC the for Integration of CAM

- Individual CAM professions should work closely with carriers to assist them in knowing when to cover their services for a specific condition, and to provide clinical algorithms to assist in supporting the claim.
- Insurers should involve the respective CAM professions when establishing CAM benefits packages.
- Participants in CWIC and their organizations should explore ways to maintain an informal network and consider seeking broader, perhaps national support for establishing an ongoing forum for dialogue and problem-solving.
- Educational strategies should be adopted for enhancing cross-fertilization and understanding of the issues of payers, CAM providers and conventional providers. Recognition of areas of mutual interest should be made explicit, and areas of divergent needs and priorities should be acknowledged and engaged constructively.
- Explore opportunities to use technology and communication to keep members aware of various methods to integrate CAM and CM.

Issues in Coverage for Complementary and Alternative Medicine Services:

Report of the Clinician Workgroup on the Integration of Complementary and Alternative Medicine

The Environment Preceding the Clinician Workgroup on the Integration of Complementary and Alternative Medicine - CWIC

After years of escalating health care costs, the 1993 Washington State Legislature adopted, and the Governor signed, health care reforms to assure that consumers in Washington could buy health insurance even if they were sick or had changed jobs**.** Subsequently, the legislature passed a law[2] that prohibited insurers from limiting coverage for a pre-existing health condition for more than three months.

As part of the 1993 reforms, health care professionals sought legislation requiring insurers to include every qualified health care provider within their networks. Insurers were concerned that limiting their ability to select competent and effective providers could negatively impact quality and cost of care for their customers. As a compromise, the legislature required insurers to include every category of licensed health care provider in the health care networks (RCW 48.43.045),[3] with an original effective date of July 1, 1995, then re-codified with a new effective date of January 1, 1996. Appendix A includes relevant laws in Washington State. Appendix B lists professions regulated by the Washington State Department of Health.

The following year, the Legislature made significant changes to the reforms, repealing the requirement that mandates all employers provide health insurance. However, several provisions were maintained, including access to every category of licensed health care provider, the right to buy insurance even when one is sick, and permitting portability of coverage when a worker changes jobs or moves.

Beginning December 1996, Insurance Commissioner Deborah Senn convened public meetings with health care providers, insurers and consumers to discuss full implementation of the "every category of provider" provision of the health care reform law. Her goal was to clarify for providers, consumers, and insurers the expectations regarding the law's implementation. A series of legal challenges[4] followed which have helped clarify the degree coverage is available and in which types of plans. RCW 48.43.045 represents the first legislative mandate in the United States to require insurers include access to every category of provider in all health care plans.

Concurrent with the legal process, the Office of Insurance Commissioner (OIC) proposed that constructive discussion between insurers and providers outside of the adversarial political and legal arenas be pursued regarding coverage and integration of "complementary and alternative medicine" (CAM) services. A forum was established with representatives from all parties involved in the legal challenges.

[2] RCW 48.43.025 (1) Preexisting conditions.

[3] RCW 48.43.045 (1): Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall: Permit every category of health care provider to provide health services or care *for conditions included in the basic health plan* services to the extent that: (a) The provision of such health services or care is within the health care providers' permitted scope of practice; and (b) The providers agree to abide by the standards related to: Provision, utilization review, and cost containment of health services; Management and administrative procedures; and provision of cost effective and clinically efficacious health services.

[4] See "Factual Chronology of Legal Events" in Appendix C.

Multidisciplinary representation was sought and discussion was focused on the issues that made CAM coverage decisions so challenging.

Although labels can be limiting, the term CAM has been adopted for this document to characterize some of the professions licensed in the State of Washington that are subject to inclusion under the every category of provider law. Specifically, CAM refers to all health care professions that are regulated in the state and, within their scopes of practice, may care for patients with conditions that are covered by the Washington State Basic Health Plan (BHP),[5] that have not previously been reimbursable, or have experienced limited reimbursement under insurance benefits. It is fully recognized that some of the professions included in this work group do not consider themselves to be "complementary and/or alternative." Some of the included professions function in primary care roles and/or are providing services that are commonly incorporated within current conventional medical practice. In like manner, for the purposes of this report, the term "conventional medicine" (CM) is used to refer to allopathic and osteopathic (MD/DO) providers and their care generally. Again it is fully recognized that other professions, such as MD's and DO's, may function as and/or provide services that can be considered complementary and alternative.

January 1997: Formal discussions convened by OIC staff and legal counsel with CAM providers and carrier attorneys to discuss coverage options.
February 1997: OIC conception of workgroup for clinicians.
March 1997: Outside facilitation sought by OIC to plan first meeting of clinicians.
May 1997: First facilitated meeting of carrier and CAM clinicians.
October 1997: Review of facilitator proposal for 1998 plan of Clinician Workgroup on the Integration of CAM (CWIC). Agreement between parties to remove legal counsel from integration discussions.

Formation of the Clinician Workgroup on the Integration of CAM

In an effort to discuss the issues of CAM integration into the conventional medical health care system without the threat of legal challenges, the OIC reached an agreement with carrier attorneys that discussions could take place with their medical directors about outcomes studies, clinical protocols, and other clinically related subjects. The discussions would not create binding decisions by any of the parties and would be facilitated by outsiders who had expertise in the CAM environment. John Weeks[6] and Lawrence Jacobson[7] were identified as facilitators for the project. Initial facilitation was paid for by the OIC to begin the discussions and to decide if there was further work to be done in a collaborative way.

In the first meeting of the clinicians, all parties agreed that a great deal of constructive work could be accomplished. This led to an "agreement" of all parties that legal counsel should be removed from the discussions to allow a safe environment to develop without barriers to in-depth discussions.

The development of a collaborative and respectful environment within the workgroup was considered key to successful working relationships and discussion of potentially difficult situations. Hence outside facilitation

[5] For a definition of the Basic Health Plan, refer to RCW 70.47

[6] John Weeks is the Publisher-Editor of *THE INTEGRATOR for the Business of Alternative Medicine*, one of the nation's most authoritative publications on the business of alternative medicine, and is a widely respected national consultant on integration. His clients have included HMOs, health systems, provider organizations and government agencies at all levels, including a role as chair of the alternative medicine track for the National Managed Health Care Congress and has an ongoing relationship with Health Forum/American Hospital Association on their CAM initiatives. His experience from 1983-1993 as Vice President for External Affairs at Bastyr University, as a board member of the American Herbal Products Association, and as Executive Director for the American Association of Naturopathic Physicians has allowed him to bring an intimate understanding of alternative care approaches to the table. Weeks writes and presents widely in the peer-reviewed and industry press. Of particular significance to his involvement with CWIC is his expertise in strategic planning and problem-solving. His contributions to practical implementation and process assured that a potentially adversarial environment developed into a meaningful and constructive workgroup.

[7] Lawrence M. Jacobson , MSW, MPH, is founder of Managed Healthcare Resources Northwest. He has 23 years experience in health care managerial positions, experience in facilitation of provider-payer relationships for the purpose of optimizing care, service and delivery effectiveness, and the development of win-win strategies among diverse groups of healthcare constituencies. Jacobson has served as senior contract administrator for a major southern California HMO, has done numerous strategic planning projects for hospital and physician organizations and has developed three behavioral health networks. His experience in developing CAM networks for insurers in Washington State and his experience with market research and customer satisfaction assessment ideally positioned him to serve as co-facilitator of CWIC. His past experience as Director of Managed Care for the Washington Health Foundation and as Medical Services Contract Manager for Pacific Medical Center and Clinics contributed unique insight to both payer and delivery issues essential to the success of CWIC's effort.

would require both background and experience of interpersonal skills and specific expertise in the area of the CAM environment. The two facilitators, each had recognized competence and experience within the CAM community, as well as strong understanding of issues in managed care, health plan development and marketing. The facilitators invested their time and personal relationships with providers of all categories to be certain that the participants would be committed to the process. Since each of the facilitators had different backgrounds, the workgroup participants were diverse, yet devoted to the investigation of CAM integration into a conventional medical health insurance system. The use of their pre-existing relationships in the CAM and CM communities was helpful in creating a collegial environment for discussion.

An OIC health policy staff representative met with provider groups to identify those categories that would be most affected by this law. A series of informal discussions with health care practitioners helped identify those considered CAM, licensed by the Department of Health, and caring for patients with conditions covered by the Basic Health Plan. Simultaneously, facilitators conducted face-to-face and telephone interviews with potential participants to further refine issues of interest and concern.

Sensitivity to the somewhat adversarial and skeptical nature of the environment was high on the part of the organizers. As a result, several strategies were employed to encourage communication and understanding. For example, seating arrangements that fostered exchange, representation and proximity of the various conventional and CAM participants was used and potential participants were interviewed ahead of time. This, along with other small group processes, supported positive interaction and new relationships. Thus, when discussions and decisions occurred, participants were made aware of those who might be missing. Over time, more mutual understanding occurred, many tensions were defused, and trust was fostered. The need for assigned seating became unnecessary by the second year, as the group had much greater appreciation of the perspectives of all parties.

A pivotal point in the workgroup activities was the use of community organizing methods originally proposed by John Weeks, facilitator, and Richard Layton, MD, Medalia Health Care.[8] This theme led to the acceptance of the facilitator's proposal of activities for 1998.

The purpose of CWIC was to develop constructive working relationships between health insurance companies, provider-based systems, and complementary and alternative health care provider communities within the new regulatory framework presented by RCW 48.43.045. The expectation of the organizers was that this could be accomplished through communication leading to education, mutual respect, and understanding of the issues of importance to each participant. Criteria for participation in the work group included the requirement that representatives to CWIC must be health care providers, with the exception of the outside facilitators. As a result, the group was able to maintain a clinical focus rather than a legal one. Outside facilitation was used to assure non-alignment with providers, payers, or regulators and to help maintain the focus on issues of multidisciplinary cooperation, availability of legally allowed services to the consumer, and coverage issues appropriate to respective scopes of practice.

Careful consideration was also given to balanced representation by providers of associations and insurers, as well as the professional affiliations and credentials of the participants. An OIC health policy staff representative was assigned as an equal participant in the workgroup itself and accepted responsibility to coordinate and schedule meetings. Because outside facilitation required funding, an ad-hoc steering committee recommended to the committee of the whole that costs be equitably borne by each participating organization. A sliding scale, based on organization size, was adopted. However, it was decided that no organization would be excluded because of financial constraints. In addition, "in-kind" support was provided for meeting sites by some of the participants. Every effort was made to make the experience a collaborative one and to preclude alienation or loss of ground already gained. A limited amount of staff time and resource support was also provided by the OIC.

A planning committee was established by the group, which included one member from each type of organization, the facilitators, and the OIC representative. For obvious reasons, the early development of the workgroup and the planning committee necessitated adherence to maintaining balanced representation and the participants went to great lengths to not exclude or ignore needs, perspectives and opinions from any participant. Over time, relationships evolved so constructively that the need to account for each participant group became unnecessary.

Unfortunately, some groups were unable to participate consistently. Most of the conventional medical providers were insurers' medical director representatives. There were other CM representatives present at different times, but very few participated consistently in the meetings. From a practicing conventional medicine perspective, there was minimal significant input.

[8] Weeks J, Layton R. Integration as community organizing: Toward a model for optimizing relationships between networks of conventional and alternative providers. Integrative Med. 1998; 1(1): pp. 15-25, 1998

1998 CWIC Activities

An aggressive agenda for 1998 was developed by the facilitators and presented to the group for consideration. Topics were refined, modified and prioritized by the group. The agenda addressed coverage decisions, technology assessment, medical necessity, collecting data and the gathering of literature on costs and practices, wellness versus condition care, and integration of CAM services, among others. A variety of strategies for exploration were adopted, ranging from didactic presentations by outside experts or group participants, workshops and training, literature and survey research, group discussion, and/or facilitated decision-making. For obvious logistical and efficiency reasons, experts within Washington State were used. CWIC Meetings in 1998 were as follows:

January 1998: Inventory of existing standards for CAM practices
February 1998: Status of coverage and use of CAM services by carriers and physician groups
April 1998: Carrier procedures for technology assessment, medical necessity determinations, and coverage decisions
May 1998: Survey of CAM patients' views of perceived benefits
July 1998: Clinical guideline training
September 1998: CAM as add-on versus replacement of conventional care in high cost conditions
November 1998: CAM integration into conventional delivery settings

Inventory of Existing Standards for CAM Practices

- facilitated group discussion and information collection

The participating CAM provider groups obtained information regarding current standards for their services, including codes of ethics, peer review procedures, managed care committee activities, quality assurance and improvement programs, practice standards, clinical documentation standards, educational programs on standards, and clinical practice guidelines. A summary matrix provided in Appendix E indicates what standards were identified by the participants as of 1998.

The facilitators developed a survey to examine current practices regarding incorporation of CAM providers within the participating payer infrastructures. They also collected information from participants regarding providers' willingness to be observed by those with an interest in learning more about their practices. In addition, information regarding interest in participating in small group education exchanges was assessed. Participants' responses collected in 1998 are included in Appendix F.

Status of Existing Carrier Coverage for CAM Services, PCP Discussion

- facilitated group discussion and information collection
- presentations by CM primary care providers and group discussion

The facilitators collected information regarding the existing degree of participation and inclusion of CAM services within the carriers' existing programs. Processes and infrastructures for making CAM coverage decisions were identified. Responses from CM physician organizations and carriers can be found in Appendix G.

The facilitators and workgroup participants were able to identify a small group of CM primary care providers (PCPs) who would meet with the group to discuss communication and facilitate an understanding of PCP needs regarding potential relationships with CAM providers. This meeting identified core issues regarding relationships between CM primary care providers and CAM providers. James Bender, MD, Virginia Mason, gave an overview of Virginia Mason's managed care

program and emphasized the need for more information regarding specific CAM standards, better understanding of managed care systems by CAM providers, and the need for better self-regulation on the part of the CAM community. Better information between provider types concerning what interventions were risky or inappropriate under which clinical circumstances was suggested.

There was also ongoing discussion of the development of an educational program to support the group's desire to expand communication on better integration of CAM within the greater health care delivery system. There was recognition of the growth of "at-risk" and capitated primary care groups' use of a gatekeeper model to manage specialty and out-of-plan referrals. One local carrier, and some other plans, were incorporating naturopathic physicians as primary care providers who met basic availability and credentialing requirements.

Technology Assessment, Medical Necessity, and Coverage Decisions

-presentations by carrier participants
-facilitated group discussion

Presentations regarding the issues and processes associated with carriers' determinations of medical necessity and coverage decisions were made. Carriers and physician groups described their approaches and distinct needs in arriving at coverage decisions. Each insurer and physician group presented a general overview about how they approach determining medical necessity, how they perform or obtain technology assessments, and their processes for utilization review and management. The majority of carriers reported using the National Committee on Quality Assurance (NCQA) or Utilization Review Accreditation Commission (now titled American Accreditation and Health Care Commission/URAC) standards when credentialing providers. These standards also influence many of the carrier's approaches regarding which services and provider types are reimbursed.

Discussion from provider participants encouraged incorporating the use of CAM providers into their decision-making processes. Medical necessity and coverage decisions regarding CAM services should involve professionals that are trained in their respective disciplines in order to arrive at accurate and fair determinations, particularly as they relate to practice context, philosophy, and scope.

Discussion also occurred regarding distinctions between holistic health care approaches within the CAM communities, compared to the condition-based care paradigm of conventional medicine. Some CAM participants suggested that consideration be given to the ways consumers use CAM services to "create health." An issue arose regarding the variation in practice philosophies among the CAM professions as well as differences from conventional medical professions.

As an example, for an acupuncturist, medical necessity is informed by a different medical paradigm than that of CM. It is based on the balance of energy, known as qi (pronounced "chi") flowing through "meridians" or channels in the body. Thus, an acupuncturist may identify a condition of "imbalance" which warrants their intervention, though to a CM practitioner, the patient may appear outwardly healthy and without identifiable clinical signs or symptoms.

Although resolution was not reached, an understanding was conveyed regarding the fundamental basis of a conventional, insurance and health care paradigm contractually implemented and priced on condition-based utilization, prevalence, and clinical progress determinations. In addition, more clarity was conveyed regarding the range of alternative health care services that make care determinations and utilization decisions based on factors deemed useful within a holistic and wellness-based paradigm. One presenting review organization also indicated that CAM providers may need further understanding of the CM billing and utilization requirements.

Survey of CAM Patients' Views of Perceived Benefits

-development of survey for participant CAM providers' patients
- facilitated group discussion

Given the lack of an extensive research infrastructure that could evaluate CAM coverage and referral decisions, discussion occurred regarding focused consumer surveys to obtain patient self-report information. Because of the limits on time, personnel resources and funding, the group decided after some debate not to do a targeted consumer survey and instead reviewed some pilots done previously. In two cases reviewed, sample sizes were small and there was a great deal of discussion about the underlying reasons why consumers may choose CAM services and not tell their CM providers. These include wanting more attention and time, seeking more control over their care, broader, more participatory care options, and less use of pharmaceuticals and surgery as first options. Key literature is identified in the list of resources.

Discussion also occurred regarding how capturing utilization data from insurers and providers might be accomplished. The need for such information was emphasized as a component of making better coverage decisions in the future. The value for informing the conventional delivery systems and providers on the more appropriate use of CAM services was also shared.

Clinical Guideline Training by Matthew R. Handley, MD

A special training session open to all participants, but geared specifically toward CAM providers, was offered on development of practice guidelines. Early in the formation of CWIC, it became apparent that the language and needs of the conventional delivery and reimbursement system differed in several ways from that of CAM providers. A clear challenge was identified in clarifying clinical decisions regarding interventions and appropriateness in terms of conditions and outcomes used to drive coverage decisions. Although potential misuse of practice guidelines by either payers or providers continues to lead to controversy, the usefulness of written delineation of clinical considerations, thresholds, and their relationship to patient presentation was understood. It was decided that training in guideline development, including consideration of scientific evidence, clinical practice issues, and building consensus was appropriate for the group.

Matthew R. Handley, MD, Associate Director, Provider Education and Guideline Development and a family practitioner from Group Health Cooperative, presented a half-day workshop identifying the pros, cons, challenges and initial steps in guideline development.[9] Of particular relevance to CWIC was his recognition of and emphasis on the need to involve physicians and providers within the communities expected to use guidelines in their development. Much of Dr. Handley's guideline work has centered on complex and multi-factorial conditions such as hyperlipidemia and psychosocial factors of chronic disorders. Issues surrounding the evidence-basis for such conditions are similar to those associated with many of the models of interest to the CAM community, thus providing a good fit for the group.

In addition to technical and logistical insight to writing guidelines, the training emphasized their appropriate use by providers and offered tactics to assist in dealing with misuse or misrepresentation by non-providers. Strategies were discussed for incorporating input from not only the scientific literature and experts, but also with involvement and refinement by providers on the front lines, using them as a resource. Well-done guidelines can be helpful by synthesizing large volumes of scientific data into an understandable format. The ideal of guideline development is to help providers and patients better understand the care options available. Given the volumes of new scientific literature, and the pace of technology development in health care these days, guidelines can be an efficient way of identifying and synthesizing information into a reasonably manageable form. The importance of using systematic approaches to reviewing literature and incorporating and reconciling gaps between science and practice was emphasized. Implementation of guidelines should include opportunities for evaluation and refinement. In this way they can assist in continuous quality improvement to reduce variation in service delivery and outcomes.

[9] Dr. Handley has most recently been involved with the National Health Committee Guidelines Program of New Zealand to develop guidelines and criteria regarding recognition of "psychosocial yellow flags" associated with chronic low back pain sufferers. His expertise in developing and utilizing evidence-based guidelines is recognized worldwide. In addition to his contribution to guideline development, Dr. Handley has extensive clinical experience in family practice and sports medicine, so insight from the practitioner perspective balanced his managed care experience very well.

CAM as Add-on Versus Replacement to Conventional Care in High-cost Conditions

- participant presentation
- facilitated group discussion

Participating CAM providers presented information regarding one to three conditions for each discipline where CAM services appear to be effective. The purpose of this exercise was to describe treatment options that could be offered and provide information regarding the general cost associated with that care. Though the group agreed that professionally-approved practice guidelines did not yet exist for some of these conditions, presentations were made by midwives, naturopathic physicians, registered dietitians, chiropractors, and acupuncturists on conditions for which they have extensive experience and track records on cost-efficient treatment options available.

The CAM providers also requested information from payers regarding how their provider members might work more closely with PCPs and insurers when considering cost-effective options. Conditions such as chronic low back pain that may be conventionally treated with medication and rehabilitation might be equally efficient to treat with manipulation and/or myofascial work. Other examples such as; pain management in labor protocols by licensed midwives, otitis media treatment and prevention by naturopathic physicians, headache treatment by acupuncturists and tendonitis treatment by massage therapists, may prove to be cost effective or cost neutral, may lower side effects and risk, or simply provide patient choice. It was suggested that opportunities to work together on specific conditions might be pursued through research and outside the workgroup.

CAM Integration Into Conventional Delivery Settings

- facilitated group discussion

This discussion addressed some of the fundamental issues regarding the opportunities and barriers that currently exist to enhance coverage of CAM services within already existing benefits structures. The core issue most challenging to address is related to paradigm differences between the dominant condition-based health care delivery and financing system, and the holistic model of disease prevention and treatment, and wellness that are employed by CAM providers. There was a general agreement on the need to encourage more of a holistic health, and wellness, orientation into the existing health care system. Many of the CAM participants expressed their ability to contribute to this effort and inquired about what they could do to help facilitate it. Discussion regarding greater incorporation of prevention strategies and early identification of disease, with the potential to increase efficiency of medical delivery, occurred with CAM providers expressing that enhanced access to their services could potentially strengthen their disease management designs.

The session focused on interfacing with the conventional system. Peter West, MD, Premera Blue Cross, presented an overview of the condition/disease-based management program upon which insurers base their rate and premium structure, and as a result, their coverage decisions. The presentation provided examples of their programs focused on diabetes and cardiac disease, emphasizing that these programs were geared to more efficiently coordinate care rather than limit it. Similar approaches are used for other populations with similar illnesses. A core question was posed, given the organization of the existing insurance system: What services provided by CAM providers could be reimbursable under the existing condition-based model? This helped prioritize work on draft seed algorithm development by the CAM representatives for the 1999 agenda.

1999 CWIC Activities

1999 CWIC Activities

The second full year of CWIC meetings were directed primarily along two directions: exploration of existing successful integrated CAM/CM practices and development of draft clinical care pathways, algorithms, and protocols by participant CAM organizations. Participants, facilitators, and OIC staff worked to identify and invite representatives from numerous integrated clinics to present their approaches and experiences to the group. Presentations were scheduled throughout the year's meetings. In addition, dedicated effort was made to train participant representatives in written clinical care pathway development. Training was aimed at using both evidence review, as well as expert and community-based consensus development, to draft written protocols in a way that non-CAM providers could understand.

In addition, discussion and planning on potential future opportunities for the group was undertaken. One task identified in 1998, the exploration of the role CAM could play in high cost conditions, was abandoned for the year, due to inadequate and non-standard availability of actuarial claims data from the carriers. It was recognized that this topic remains important, but it will clearly require adequately funded health services research activity in order to be meaningful. As a result, and based on the recognition of the need for enhancing CAM research in numerous areas, the group directed the planning committee to explore potential future research activity in greater depth. Large group meeting agendas for the year included:

April 1999: Multidisciplinary clinic presentations (Seattle Cancer Treatment Centers of America, Center for Comprehensive Care, Seattle Healing Arts); discussion on insurable practices.
April 1999: Clinical care pathway and algorithm training.
June 1999: Multidisciplinary clinic presentations (Harborview Medical Center, Swedish Hospital Dean Ornish Cardiac Rehabilitation Program); CAM practices survey project presentation; discussion on high cost conditions.
June 1999: Research planning meeting with University of Washington and Bastyr University researchers interested in CAM; presentations from Bastyr University, University of Washington and CWIC participants.
September 1999: Multidisciplinary clinic presentations (Community Health Center King County); presentation of draft algorithms by participants.
October 1999: Multidisciplinary clinic presentations (Puget Sound Birth Center); presentations of draft algorithms by participants.
November 1999: Conclusion and summary of CWIC experience, review of material and information for inclusion in final report, and presentation by Deborah Senn, Insurance Commissioner.

Exploration of Approaches Used by Existing Integrated CAM/CM Clinics.

- **presentation by representatives from facilities throughout Puget Sound**
- **multidisciplinary clinic questionnaires**
- **facilitated group discussion at multiple meetings**

While planning the 1999 activities for the workgroup it was agreed that understanding how integrated clinics operate would be of benefit. The planning committee identified several clinics that marketed themselves as integrated or were known in the health care community for using a multidisciplinary approach. In order to help standardize the information participants were most interested in, each presenter was asked to fill out a survey developed by the group, highlighting key attributes of their clinical setting. Among the attributes for which information was requested were: focus of the clinic, patient triage protocols to and from CAM providers, inventory of provider types on staff, characteristics of

interdisciplinary communication at the facility and any available information about outcomes and satisfaction. In addition, information about reimbursement for CAM services and general acceptance of the CAM providers' work within the CM community was requested. This process resulted in development of a questionnaire and involved expert presentations by integrated clinic practitioners. Summaries of their responses can be found in Appendix H.

The presentations demonstrated that there are many ways to run an integrated clinic, and that no particular strategy seems to stand out as "the" most successful practice model. All but one of the clinics (a licensed birth center) had at least four different types of providers on the premises, whether or not they were either subcontractors or employees of the clinic. Several of the clinics indicated that low levels of reimbursement for CAM services were an issue, and that often reimbursement was delayed compared to reimbursement for CM services. Each presenting clinic indicated that there had been initial resistance from the conventional medical community and that resistance decreased as familiarity and communication increased. Most clinics also indicated that they had received referrals that were treatment failures of both CM and CAM interventions. Some presenters indicated that an integrated approach contributed to higher satisfaction on the part of patients and appeared to have enhanced successful outcomes from care. One presenter suggested that patients who do not respond within the standard modality time frames and exceed the ability of the third party payer to continue reimbursement could also be considered a failure of the system overall.

The presentations and questionnaires provided by the multidisciplinary clinics during 1999 were valuable. Care models presented concerning service delivery, effectiveness and gaps in coverage. This helped lay the groundwork for further study and for developing models of integrated care delivery. The presentations also clarified significance of integration across a range of provider types within the community.

Clinical Care Pathway and Algorithm Training by Robert D. Mootz, DC

- **in-service workshop training**
- **follow-up presentations and discussion by group**

Based on the 1998 discussions between carriers and CAM participants, it became clear that a fundamental requirement for understanding of CAM services would be the development of written care protocols. In recent years, clinical practice guidelines have grown in number and quality for conventional medical services. However, practice guidelines remain controversial and offer multiple challenges. In an ideal setting, guidelines should help providers and patients synthesize extensive amounts of scientific data and expert opinion into concise, meaningful protocols that can help patients and providers sort through various options in order to make the most informed decisions about how to proceed.

In reality, practice guidelines are subject to the limitations of evidence and human nature. Unscrupulous or ill-informed end users (be they payers or providers) can misuse or misrepresent a guideline's purpose, intent, or value. Guideline quality can also be highly variable. Recognizing these concerns, the group sought training to better understand the nature, strengths, and limitations of guideline and care pathway development. During the 1998 training, Matt Handley, MD presented methods for developing guidelines as well as steps to take in creating them for conditions addressed by CAM providers. Dr. Handley described purposes of clinical guidelines and how they differ from other types of guidelines. He described the importance of individual professions and disciplines being involved in developing their own guidelines. Dr. Handley also offered insight into who should be involved in the process and who should not. He also helped set the stage for developing strategies for sorting through vast amounts of information and working with groups to obtain consensus. Since the large size of the 1998 agenda precluded the ability to develop specific care protocols for CAM services, the group set this task as a 1999 priority. Specific disclaimer language can be found in Appendix I.

Robert D. Mootz, DC, Associate Medical Director for Chiropractic at the Washington State Department of Labor and Industries[10] provided a day-long workshop on care pathway and algorithm development. The session aimed to develop skills in writing condition-specific care pathways and clinical algorithms. Participants were provided with an extensive collection of published literature and numerous examples of such pathways and algorithms for both CAM and CM procedures. The group was also taken through decision-tree logic and worked through examples of algorithm writing. Because the health paradigm under which CAM providers function may differ from CM perspectives, the concept of insurable and reimbursable services described by carrier representatives in 1998 was expanded upon. An approach taken by the group was to consider initial care pathway development exercises to focus on "insurable practice

[10] Dr. Mootz is a chiropractic physician now working in a fulltime government health policy and research capacity and is editor of a clinical journal, *Topics in Clinical Chiropractic*, focused on the publication of clinical care pathways. He has been involved in several guideline and care pathway development efforts and served on the faculty of the Institute for Healthcare Improvement multidisciplinary training of large clinics, hospitals and employer groups to use continuous quality improvement methods to enhance patient outcomes.

descriptions" rather than "guidelines." Dr. Mootz encouraged the group to identify which services might interface with the clinical thresholds payers need to make reimbursement decisions. The importance of writing them in such a way that the respective disciplines philosophic basis would not be undermined was emphasized by all.

In addition, specific emphasis was given to developing disclaimers for specific work to help keep care pathways and guidelines in their proper clinical context. The importance of developing guidelines in a way that informs patients and providers about the options and decisions to be made was emphasized. Participants were cautioned against simply writing them "defensively," e.g., for the singular purpose of meeting a payer's actuarial need or to counter coverage decisions providers disagree with. Unless care pathways accurately reflect meaningful clinical decisions, they are more likely to be subject to misinterpretation or misuse.

Algorithm Presentations by CAM Providers[11]

This training set the stage for participants to establish workgroups, or engage in existing workgroups, within their respective disciplines to draft seed pathways to share with group at year's end. The presentations by the professions reflected a great amount of work and led to a much clearer articulation of the services and clinical rationales described. During the presentations, substantial constructive feedback occurred and this exercise contributed to a great deal of learning.

Not only did many of the medical directors with the carriers express their respect for the work, but the workgroups involved in the process communicated the intrinsic value of explicitly delineating the thought processes they go through in making clinical decisions.

The issue of the paradigm differences was often raised by the CWIC participants and has been commented on throughout the report. Using tools from the guideline training, and with a better understanding of the constraints under which carriers must function, the CAM professions were able to better delineate how their various paradigms impact clinical decision-making.

Some participants indicated that clinical steps in practice guidelines can reflect uniqueness of their practice philosophy, and ways of approaching this should be explored. Practice guideline development is a common tool that can facilitate improved communication between CAM and CM providers and carriers concerning clinical issues and activities within the context of respective paradigms.

Development of useable guidelines is time and resource intensive. Carriers observed an array of strategies for condition management used by different types of CAM providers when the CAM professions presented their draft condition-specific algorithm.

The experience was considered to be very useful and many CAM provider representatives indicated there is interest within their organizations and institutions in further refinement of these pathways and development of additional ones. Examples of the "insurable service descriptions" drafted in 1999 are included in Appendix I. It needs to be emphasized that these are presented for educational and illustrative value in this report. These algorithms are presented in draft form and should not be considered as definitive clinical management protocols endorsed by the CWIC, the OIC, or any of the CWIC participants and their respective organizations. None of the draft seed algorithms included in this report have been approved by any association, educational institution, or other professional societies or organizations.

Research Interests of the CWIC

When the CWIC was first established there was an expectation that research needs would be identified. By 1999, the group had identified a substantial number of research interests and had begun to initiate dialogue with various investigators involved in CAM research. Daniel C. Cherkin, PhD, Associate Director, Internal, Senior Scientific Investigator at the Center for Health Studies at Group Health Cooperative of Puget Sound, presented a preliminary report of the progress of a survey being conducted on selected CAM providers.[12]

He reported on a CAM provider survey project being done in collaboration with CAM providers, including investigators and consultants who are members of CWIC. Surveys similar in design to those used in the National Ambulatory Medical Care Survey were developed for acupuncture, massage, chiropractic, and naturopathic medical practices in several representative states around the country. The surveys obtained information from providers immediately following patient visits about patient condition, clinical evaluation and interventions used, communication and referral. The unique feature of this work is it is collecting detailed information from four kinds of CAM providers about decisions and procedures

[11] Presenters of each profession are identified by an asterisk (*) next to their name in the participant acknowledgements pages iii and iv.

[12] Dr. Cherkin is a noted health services researcher who is responsible for numerous projects including the federally-funded Back Pain Outcomes Assessment Team, and has co-edited a US government report on chiropractic. He has also been an investigator on clinical trials examining chiropractic outcomes and is currently studying outcomes of care for low back pain comparing "usual care", chiropractic, acupuncture, and massage approaches. He is well-known for his work on patient satisfaction.

used on patients at the time the provider is actually performing them.

Dr. Cherkin shared some early preliminary findings with the group and indicated that the project will be fully analyzed with completed reports sometime in the year 2000. The work was expected to be of value by the respective CAM provider groups in order to inventory what is being done in the field.

A separate meeting was held with research scientists from the University of Washington (UW) and Bastyr University that either had CAM research in progress, or who had an interest in CAM research. Presentations included a wide variety of research projects currently underway, such as the use of pulsed magnetic therapy for multiple sclerosis and the use of herbs for menopause. The meeting drew a great deal of participation and provided some framework for what could be done. Subsequent meetings identified potential funding opportunities with potential principal investigators from the UW and Bastyr, as well as to consider existing research underway. Although the CWIC as an entity itself would not be a source or recipient of CAM research funding, it represents a unique vehicle for communication and collaboration between providers, purchasers, and regulators within the health care industry. It was felt that the dynamics, work products and relationships established during the three-year project could be harnessed for future work. Consideration of further collaborations and research agenda identification continues by the participants.

Conclusion and Summary of the CWIC Experience

- review of material and information for inclusion in final report

-presentation by Washington State Insurance Commissioner Deborah Senn

During the last scheduled meeting of the CWIC time was scheduled to review the group's activities and accomplishments, identify specific value attained from the project, and explore next steps. The group established writing and editing committees to work with the OIC staff and facilitator to prepare the final report and recommendations. Insurance Commissioner Deborah Senn attended to express her appreciation for the collegial and collaborative nature of the group and its hard, principally volunteer work. She indicated that the group had achieved the objectives she had set. The Commissioner also commented that the communication and partnership established in the project was on the cutting edge in the industry. She also indicated that no decisions have been made on further involvement of the OIC on future work with CWIC but that more discussion would be forthcoming based on the requests of the members and needs of the community.

Conclusions of CWIC

Variations in Coverage Strategies for CAM

There are currently several different coverage models for CAM services in use in Washington State. No preferred or "right" ways of including these benefits are being recommended by the CWIC. Each approach has advantages and limitations for various constituencies. At this point, decisions on what and how to include CAM services will require evolution and refinement in the marketplace. Several coverage approaches are identified below.

Dollar Cap: The dollar cap model is a straightforward benefit that generally applies a maximum dollar amount allowed in a given coverage year for a set range of CAM services. Acupuncture, massage therapy and naturopathic medicine are the most commonly included services under this model. Chiropractic services are typically separated from the CAM dollar cap because chiropractic is frequently covered under its own rider, and there is a mandated offering law in Washington State for coverage of chiropractic services. Some plans may include direct-access for chiropractic services and others treat it as a specialist "physical medicine" service requiring PCP referral. Midwifery may be a covered benefit as well, but is usually not subject to a dollar cap, only referral requirements for maternity as a covered benefit, and when the carrier contracts with midwives. Other covered CAM benefits may require referral from a primary care provider and do not cover any naturopathic medicines. In addition, patients must pay necessary co-pays and any deductibles that may apply.

Condition Based: This CAM coverage model bases benefits on allowances related to specific clinical diagnoses or conditions, such as the use of acupuncture for pain or naturopathic care for migraine headache. Often the carrier uses "preferred" specific providers that have met a carrier's credentialing and/or geographic distribution requirements. The covered benefit may require specific clinical regimens to have been followed prior to referral for CAM services, such as a course of physical therapy prior to authorizing massage therapy. The condition-based approach may reimburse for some naturopathic medicines and usually requires a PCP referral from within their network. Patients are also responsible for co-payments and any deductibles that may apply.

Gatekeeper Method: The gatekeeper model is frequently employed under managed care coverage strategies. A unique difference with the gatekeeper model is that in some cases the naturopathic physician is eligible to function as a Primary Care Physician. Patients seeking CAM services to be covered under their insurance benefits need to have a referral from their PCP, whether the PCP is an ND, MD, DO, or ARNP. The benefits are subject to the usual medical necessity requirements established by the insurer, but may be determined by the at-risk PCP group as well.

Open Access Model: This model is built on a strong care coordination and quality infrastructure that allows the integration of CAM and CM practitioners and their services. This design allows a member to access network providers of all categories without the requirement of a PCP referral. In fact, the member is not required to designate a PCP and there is no "gatekeeper."[13]

[13] Some insurance products outside the purview of CWIC, such as personal injury protection and workers compensation, also serve as examples of open access. Under Washington State Workers' Compensation, both naturopathic and chiropractic physicians hold attending doctor status along with medical and osteopathic physicians, and others. It should be noted that Workers' Compensation benefits are not regulated under the Office of the Insurance Commissioner. Rather, a separate agency, the Department of Labor and Industries, is charged with this oversight. Although personal injury protection (PIP) provides health care benefits, it is part of an automobile insurance policy and is therefore not regulated as health insurance.

Self-Referral and Preventive Care: The self-referral method of coverage is available usually when there is a rider benefit involved. In some circumstances, such as the State's Workers' Compensation program, self-referral to designated attending doctors is allowed. In a few cases, some benefits plans allow a patient to self-refer for a CAM service with specific limitations. These are usually related to a dollar cap or set number of sessions with a particular provider type. Although the self-referral approach method does not usually require a PCP referral, benefits are subject to medical necessity determinations made by the carrier.

Frequently the self-referral approach may be implemented in conjunction with a preventive care benefit. This may involve the purchase of a specific rider or unique product that includes the benefit. Typically, a policyholder may be able to access CAM services for a limited number of sessions with no referral and at higher co-pays than required of other conventional services.

***Discount Networks*:** Recently, some insurers have begun to negotiate discounts with CAM providers for their policyholders in exchange for being listed in their approved provider guide. These carriers do not provide reimbursement for the members expenses for the services. This requires all CAM costs to be paid by the patient. This approach is sometimes referred to as an "affinity" plan and is a contractual agreement between the CAM provider and the network to provide a substantial discount to the members of that plan.

Lessons Learned

Despite the demonstrated good will of all parties, it was challenging to keep CWIC issues in the forefront of participant organizations' agendas. This was especially true for health plans and physician groups. When these groups were under-represented, CWIC meetings had a different impact. The time commitment for each participant was significant and affected the provider's practice as well as the organizational staff representative's workload. In many cases the representatives were able to participate in the CWIC because of their personal dedication to advancing the process of integration in addition to that of the organization they represented.

The participation of diverse, multidisciplinary parties provided great value for potentially improving health care via a broader range of more professional communication. It was important to identify and understand the distinctive roles of providers, versus payers, as well as the conventional system of medical practice from all perspectives. From this, the Workgroup learned:

- Better understanding of each other's language and clinical theory is needed.
- A forum of insurers/providers is a valuable environment for discussing coverage, payment, and cost concerns.
- Creation of resources is needed for use in other like forums.
- Building trust and relationships breaks down barriers.
- The CWIC process increased awareness of the multifaceted nature of the current health care delivery system.
- Payers began to see the value in CAM delivery experience; providers gained understanding of managed care systems.
- Many of the changes in health care have resulted from market-place factors that are frequently beyond the direct influence of providers, payers and regulators.

The principles of managed care and insurance that impact health care delivery include "medical necessity", evidence-based decision-making/quality assurance, coding/billing, credentialing, guideline/algorithm development, and coordination of care. By providing opportunities for multidisciplinary interaction, we can engage in meaningful dialogue and establish common goals. This process can lead to mutual respect and understanding. Most participants acknowledged the complexity and length of time needed to improve the integration of CAM with CM, as well as working toward better integration of all health care.

Health carrier participants requested that CAM providers present draft seed algorithms. The CAM providers for each discipline prepared at least one clinical guideline algorithm as an exercise to teach their associations the process. There are numerous models for care integration between CAM providers and conventional medical providers. Some providers are in the same locations, some focus on limited specialties, some are more closely aligned with primary care providers. It was the CWIC's experience that there was significant benefit to having some small group interaction in the first few meetings to establish an interactive model for communication. Continuous time commitments of key representatives were essential to keeping the process on track. A baseline value system developed that encouraged each member of CWIC to listen and recognize the value of other points of view.

Members agreed that improved coordination of care, including greater CAM provider input was a worthwhile model to consider. There was recognition that the current health care system is not ideally organized. Many participants emphasized that approaches offered by some of the CAM disciplines incorporate self-care and seek the most benefit for the least intervention. Seeking a balance between the interests of the marketplace, the usual and preferred practices of various disciplines and patient preferences will require attention and careful consideration.

Providers can gain from an increased understanding of the concepts of quality improvement, clinical guidelines and practice standards. Given constraints on

time, participant availability, staffing, and financial resources, it was important for the facilitators, coordinator and planning group to keep the agendas focused and to budget time appropriately. Some subjects were well beyond the scope of this workgroup due to their complexity and the time and resources that would be needed to address them. Many of these topics have been included in the "Next Steps."

Next Steps

The health care delivery system, both in Washington State and nationally, is experiencing continuing change. With the expectation that external forces in the economy, as well as in science, will exert influence on care delivery, the workgroup has identified the following "Next Steps" for further Integration of CAM into health insurance benefits and reimbursement systems

Research

The workgroup identified that research of CAM for efficacy, cost impact and utilization was a top priority with the awareness that the workgroup does not have the funding to initiate this work. What the workgroup does have is an established level of trust and a working relationship that will provide a collaborative advisory panel for any research that is to be conducted in the future. Additionally, the workgroup's subcommittee on research has identified principal investigators who are willing to work in a collaborative effort to try to answer questions related to the previously mentioned topics. Finally, the workgroup has the written support of insurers to share data with a responsible party appropriate to conduct the research, while recognizing the sensitivity of such a project. The following are some areas identified for future research:

- Collection and analysis of provider network and plan experience data, following implementation of RCW 48.43.045
- Identify ways to enhance funding for research on CAM clinical efficacy and cost effectiveness.
- Initiate a pilot project to quantify potential cost offset of specific CAM treatments for specific conditions.
- Increase research that can facilitate integration for best outcomes.
- Establish an advisory group to support ongoing research on CAM effectiveness.
- Conduct comparative outcomes studies for different CAM approaches and multi-disciplinary care.
- Gather outcome data on "best practices," based on tracking patients who have received specific treatments for specific conditions.

Care Management Considerations

Many of the subjects that have been discussed by the workgroup carried an overall theme of care management. For example, a number of questions arose such as: how can care management be positively affected by these discussions? Do the participants have the authority to go back to their organization and make an administrative change that would impact the management of care, resulting in increased access to CAM services?

It was decided that continuing work on refinement of referral criteria and systems was an important Next Step for the respective participant organizations, if not actually a direct activity of the CWIC as a future entity. There are many opportunities for CAM and conventional providers to collaborate and even integrate through joint guideline development discussions. However, specific CAM guideline development will require internal and/or external funding for such an initiative to be accomplished. Delineation of appropriate referral criteria and coordination of care to decrease redundancy of procedures, or similar services, were identified as useful areas of future work. Increasing multidisciplinary integration in management of specific conditions, including identification of reasonable treatment options, was identified as another area for future attention. Even when a guideline or algorithm does not specifically address integrated or multidisciplinary issues, the process of developing guidelines and algorithms to assist in decision-making for covered benefits is important to respective practitioners in care management.

An additional issue brought up throughout the existence of CWIC was how to determine appropriate billing (CPT)[14] and diagnostic codes (ICD-9)[15] used by CAM providers. Development of new codes is an extremely resource-intensive effort and is done principally on a national level by the US Health Care Financing Administration and the American Medical Association. To date, chiropractors and dietitians are the only CAM providers who have voting membership on the AMA's Health Care Professions Advisory Committee (HCPAC), along with physical therapists, occupational therapists, psychologists, optometrists and speech therapists. This group advises the American Medical Association and Health Care Financing Administration workgroups on CPT codes and their values and has one vote (combined) among the numerous medical subspecialties. Very few of the CAM professions have actually performed practice-resource research used in developing specific procedural codes and relative value scales. However, some other CAM professions, including acupuncture and naturopathy, have made submissions of

[14] Current Procedural Terminology
[15] International Classification of Disease, 9th Edition

their concerns about coding to the HCPAC for consideration.

Many of the CAM providers expressed interest in utilizing existing codes, however, this can be a source of controversy for payers and regulators when the codes are not developed with resource data for CAM providers in a similar fashion to what was done for all of the individual medical specialties. In addition, many services that CAM providers perform (e.g., many acupuncture procedures) are not accurately described by existing CPT codes. Some providers expressed concern that tiered, or separate coding can be perceived as a "second class" form of coverage. Although some progress has been made regarding inclusion of coverage for CAM services, a great deal of work and research on resource costs, similar to that done by all of the medical specialties may need to be undertaken by other CAM provider groups. Some insurers may also have an interest in developing payer-specific codes to describe work done by CAM providers until inclusion at the national level comes about by the HCFA and AMA workgroups.

Additional considerations regarding care management include:

- Establish ongoing CAM provider workgroups to develop and refine practice guidelines, "best practices" and algorithms.
- Establish a CAM development committee to advise insurers and primary care organizations, policy analysts and purchasers on policies; e.g., utilization management, "medical necessity", etc.
- Continue contact among workgroup participants to address new issues and provide peer support.
- Continue dialogue with payers and CAM disciplines on a regular basis.
- At least twice yearly, convene CAM providers, conventional providers and insurance representatives to discuss care management issues and how they relate to CAM.
- Include conventional and CAM providers in all discussions of practice integration.
- Inform broader constituencies (e.g., health care consumers and purchasers, providers and members of the insurance industry) of discussions and approaches identified from CWIC (or similar future forums) regarding CAM/CM interactions.
- Establish a clearinghouse for CAM industry information such as standards and practices, clinical algorithms and guidelines, contact personnel and the like.
- Identify potential strategies and funding sources for accomplishing these tasks.

Education

Licensed midwives and naturopathic physicians, along with many conventional medical health care practitioners, are all identified as general care providers in the Washington State Health Personnel Resource Plan[16]. The members of these professions are eligible to receive scholarships and loan reimbursement through the Health Professional Loan Repayment and Scholarship Program for the State of Washington. Unique to licensed midwifery is the inclusion of their services for benefits paid by Medicaid and that they are accessible through the Basic Health Plan.

An important byproduct of CWIC was the amount of education for all parties regarding each other's needs and perspectives achieved within a very short time frame. Information gained can be used to incorporate parties who were not involved in the original workgroup. Strategies and techniques for dialoging with primary care providers about their needs, and providing information about CAM providers' roles and scopes of practice can now be developed. Opportunities for further education and training about CAM within conventional medical educational settings should be identified. Qualified CAM providers with good communication skills, interest, and availability for such activities should be identified.

Collaborative Forum for Communication

It is clear that the process that CWIC provided is a one-of-a kind model for communicating on cost, coverage, and other issues. The members expressed a desire to establish an ongoing forum to advise and support the OIC on issues of integration that affect health insurance.

Some participants suggested that the Clinician Workgroup on the Integration of CAM be expanded to a national level. It was suggested that CAM professional associations and their accredited colleges, as well as conventional provider associations such as the American Hospital Association, the American Association of Primary Care Physicians, American College of Obstetricians and Gynecologists, and the American Medical Association should be included. If a forum such as the CWIC continued, a vehicle for conveying experience data and addressing coverage issues could be established. Such a forum might also serve as a springboard or template for identifying individuals who could serve as an independent advisory or review panel for providers and health plans at some point. There will be a need to identify specific roles and purpose of such a group as well as to identify funding mechanisms for such a forum.

[16] Washington State Health Personnel Resource Plan, Washington State Department of Health, 1994

Integration of CAM and CM Services

The concept of integration should be operationally defined and the advantages and limitations of integration models should be more thoroughly explored. Additional study of relationships in existing settings should be expanded, perhaps to national settings in order to delineate the range of possibilities that exist. Among the attributes of integration that need more elucidation are:

- Range of provider types that make up "integrated" practices
- Differences between joint (on-premise) practice settings and inter-referral arrangements between different offices and clinics
- Range of services covered by insurers
- Roles and establishment of CAM advisory groups
- Credentialing and care standards for CAM providers, particularly related to professional liability issues
- Structures of holistic healthcare models incorporating broad approaches and optimizing health
- Exploration of juxtaposition of different health paradigms (condition versus whole person health care, and prevention)

Among the biggest challenges for health purchasers, providers, and regulators will be defining and operationalizing clinical thresholds such as when referrals are indicated or what constitutes medical necessity for CAM services. Another challenge will entail development of best financing mechanisms for wellness and preventative services**.** The economics of cost sharing between at-risk and not-at-risk populations will require study and market testing. Currently, there is inadequate experience or research to quantify if potential cost-savings from purchasing holistic and/or preventative services for everyone can really occur. Some of the knowledge developed through the CWIC project can serve to lay the groundwork for addressing these and other issues. Exploring how multidisciplinary models can be used more broadly in the health care field generally should be pursued.

Overall, this represents a large number of Next Steps and will require both personnel and financial resources. Some external, governmental, and philanthropic sources may be identified, however individual payer and provider organizations should pursue this according to their needs.

Key Issues Regarding Integration

The key issues related to integration of CAM identified by the CWIC include:

Relationship Development: As a multidisciplinary group of individuals coming from very different points of reference, it was critical that a core value within the group was mutual respect and openness to new ideas. This value was the basis that formed the foundation for relationship building. By facilitating a process that maximized interaction of various disciplines and encouraged communication, we fostered learning and idea exchange that allowed exploration of others' points of reference. An environment was cultivated that allowed new members to join easily and encouraged trust.

Speaking Different Languages: Patience and openness were required attributes given the divergence of training, philosophy, and professional experience the group brought to the table. Health care professional training programs range from six-month certificate programs in community-based or vocational schools to post-graduate degree programs with extended residencies.

An understanding and acknowledgement of the context from which the various disciplines came was essential in order to gain perspective of how different providers formed their opinions. In addition to the experiences and training that lead to various perspectives and practices, each discipline has also evolved its own syntax that could be a source of confusion or misunderstanding to payers and CM practitioners.

Learning Each Other's Paradigms: Respective paradigms for training, attitudes toward healing and interventions, care coordination and approaches to reimbursement were variable across the continuum of participants. Acknowledgement of differences in perspectives from disease-oriented models compared to holistic models is essential to successful idea exchange. An appreciation for how this can translate into unique approaches to patient involvement, differences in patient expectation and responsibilities, and short-term versus long-term goals for intervention was also conveyed. For example, CAM paradigms typically address both acute and chronic disease by embracing health restoration processes that are directed at individual's needs, as well as overall health improvement, which may or may not directly relate to the diagnosed condition. This can create confusion within conventional delivery models, yet serves as a common rational approach among many kinds of CAM providers.

Algorithms and Guidelines: There was extensive discussion and work done by CAM disciplines to understand and utilize guidelines in order to better explain how the interventions they provide can be applied under specific clinical circumstances. It was recognized that reimbursement under current systems requires accountability from all providers including substantiation of clinical need for services. Algorithms and guidelines can help clarify clinical decision points and convey the clinical context under which decisions are made.

Efficacy of Treatments, CAM and CM: It is recognized that many CAM treatments have not established efficacy based on scientific study, however the same holds true for many CM procedures. Development of a CAM research structure comparable to

that of CM is unlikely to evolve rapidly. The importance of enhancing the evidence base for clinical interventions is acknowledged and encouraged. Many CWIC members emphasized that the "absence of evidence" should not be equated with "evidence against", which is often what happens in the delivery and reimbursement world. However, as with CM procedures that have an extensive history of utilization prior to thorough research validation (e.g., physical examination), there may be difficulty obtaining resources to determine efficacy of some CAM procedures. Collaboration and synthesis of knowledge and experience should be prioritized and reasonable consideration to patient preference and CAM expert opinion and experience should be placed in appropriate perspective. All providers must seek the best tools in the service of patients, and particular consideration should be given for those complex and chronic disorders for which conventional approaches have not been successfully addressed.

Members May Have Different Needs: Some members saw their involvement as seeking the best care options for patients. Some members felt their role was to meet the needs of the law. Some felt that they were involved to explore the most cost-effective treatment options. Some members recognized the essential role that patient preference is playing in the evolving health care system. The health care delivery system involves multiple constituents, and the vantage points of each have validity. A forum to exchange needs and constructively solve problems makes an important contribution, particularly in sensitive environments where the potential for adversity is high.

Recommendations of CWIC for the Integration of CAM

- When coverage decisions are made, individual CAM professions should work closely with carriers to assist them in knowing when to cover their services for a specific condition, and to provide clinical algorithms to support the claim.
- Insurers should involve the respective CAM professions when establishing CAM benefits packages.
- Participants in CWIC and their organizations should explore ways to maintain an informal network and consider seeking broader, perhaps national support for establishing an ongoing forum for dialog and problem solving.
- Educational strategies should be adopted for enhancing cross-fertilization and understanding of the issues of payers, CAM providers, and conventional providers. Recognition of areas of mutual interest should be made explicit, and areas of divergent needs and priorities should be acknowledged and engaged constructively.
- Opportunities should be explored to use technology and communication to inform interested parties of various methods and issues regarding integration of CAM and CM.
- In general, sources of funding and resource support need to be identified for all of these activities.

Conclusions

The three-year-long CWIC process has been exciting and challenging in its scope. By virtue of having broad, multidisciplinary member participation, and by attempting to address many complex issues, it created a high set of expectations. As a process for bringing these issues to the discussion table, most would acknowledge the CWIC as a success. New and important relationships have formed and interdisciplinary dialog has been opened in a way previously unheard of. Many of the key questions and concerns have been identified and discussed, and although many issues remain unresolved, agendas for further work and research have been identified. All participants in the process have acknowledged gaining valuable insight and perspective. Many have used the process as a springboard for innovations in their approach to integration and coverage issues as well as communication.

From a work product standpoint, the successes were more subtle. There was insufficient time to accomplish everything that the broad array of participants might have hoped for. Personnel and financial resources were limited. Yet through hard work, significant risk taking, and dedication of financial resources by the participants themselves, initial work was begun on protocol development, interdisciplinary dialog and cooperation has ensued, and initiation of research grant writing has taken place.

The unique health care environment in Washington State provides a fertile arena to explore the issues of CAM integration. The prevalence of CAM services, the legislative mandate of "every category provider", and the market interests of the State's health care consumers have all contributed to and enabled the discussion. However, the biggest challenge for additional progress will continue to be obtaining ongoing commitments from the involved parties and their organizations. Much of the challenge has to do with external demands on participant time and their respective organization's priorities.

CWIC believes that with few exceptions, all the organizations that participated over the course of this work have, by their involvement, agreed that these questions are important to our region's health care delivery system. The workgroup rapidly gained mutual respect, despite many initial concerns. The recognition of common interests in the health of patients individually and on a community-wide basis served to coalesce into a problem-solving mindset over a respective self-interest

one. All sides took risks at times and engendered apprehension and skepticism from their peer constituents.

Even so, an open-mindedness and willingness to exchange ideas above personal feelings permitted education and innovation to occur. All involved made personal sacrifices by taking time out from practices, juggling and postponing organizational obligations, and engaged in the continual persuading of constituents and superiors to see the process out. For this, the participants deserve acknowledgement and thanks from the greater health care community. There is no doubt the work ahead is far greater than that yet accomplished. As is pointed out in the section on Next Steps, most participants are striving to see this process continue, albeit in a different form and context.

Integration of CAM services is not a passing fad, nor simply a statement of dissatisfaction with the conventional medical system. As research has already documented, health care consumers perceive value in CAM with out-of-pocket expenses for alternative care equaling or bettering out-of-pocket expenditures for primary (non-hospital) conventional services. The rate of use of CAM services continues to increase. Research dollars from federal agencies including the National Institutes of Health and the Health Services Resources Administration are funding research, education and infrastructure development for these services. Yet there is so much more that needs to be done.

The inclusion of conventional medical providers, hospital representatives and institutions of medical education was an important element to embed the CWIC process into the medical community. Many misunderstandings and biases have been dispelled on all sides. The language and perceptions of payers and CAM providers alike have been clarified. The health care environment will continue to change. Consumers are demanding access to the best elements from both CAM and conventional care. The digital information age is empowering consumers with more insight and understanding of health care options.[17]

As a result, knowledge that was once the exclusive province of learned proprietary professions is available to anyone with a connection to the Internet. Change is certain. While unbridled change can be chaotic, informed change associated with interactive adaptation can help foster innovation and meaningful outcomes that address interests of consumer, health care provider, business, and regulator alike. The participants in the CWIC process perceive their efforts as contributing to the latter.

[17] Additional resources and references for CAM information are listed in Appendix J.